PROMISING PRACTICES IN HOME AND COMMUNITY-BASED SERVICES

Alaska – Program Changes based on System Principles

Issue: Consumer-Directed Personal Care Program

Summary

Alaska changed its Medicaid State Plan personal care program based on principles and recommendations from a 75-person Personal Care Summit in 1998 that involved program participants, personal assistance providers, advocates, and state policy makers. The changes created consumer-directed personal care agencies that employ attendants chosen by the participants and that train participants to hire and supervise their workers. The personal care agencies also perform fiscal responsibilities such as Medicaid billing, tax withholding, and liability and workers' compensation insurance. The percentage of personal care participants who hired and supervised their attendants increased from 10 percent to 75 percent in the first two years after the 2001 changes.

Introduction

In November of 1998, Alaska's Division of Senior Services sponsored a Personal Care Summit of stakeholders to solicit views and opinions on the future direction of Alaska's personal assistance services. That summit started a process in which Alaska changed its Medicaid State Plan personal care benefit to give program participants more choice and control. As a result, Alaska established a Consumer-Directed Personal Care Program (CDPCP), in which agencies provide fiscal intermediary services and training to participants who select and manage their personal assistance services.

This report briefly describes the creation and implementation process of the CDPCP, the consumer-directed agencies, and the services provided under the program. This document is based on reports by Alaska's Department of Health and Social Services, Division of Senior and Disabilities Services and interviews with people from state and consumer-directed agencies.

Prior to the Consumer-Directed Personal Care Program, participants did not receive support when hiring their own provider.

Background

Prior to CDPCP implementation, Alaskans could receive Medicaid personal care from traditional personal care provider agencies or from independent providers. The independent provider option presented challenges for both participants and direct support workers. Program participants received no support or guidance from the state regarding how to select and manage their attendants. The attendants needed to enroll directly with Medicaid and were responsible for their own Medicaid billing. Also, as self-employed independent contractors, independent providers did not receive common employee benefits like workers' compensation insurance, unemployment insurance, and medical benefits.

Intervention

Under the CDPCP, consumer-directed agencies provide training and fiscal intermediary services to participants. During the training session, participants receive a training manual that provides ideas on how to develop job descriptions and checklists as well as suggestions on how to recruit, interview, train, manage, resolve conflict, evaluate, and keep records. Participants also receive training on

developing back-up plans, which Alaska requires in each participant's service plan. Consumer-directed agencies offer additional voluntary training to participants and support workers.

In addition to training and fiscal intermediary services, CDPCP participants have more flexibility in the services they can receive than under the previous independent provider option. Under CDPCP, participants can receive additional services including routine health maintenance activities such as urinary system management, medication administration, stand-by assistance with specific tasks, and increased time for shopping assistance.

CDPCP participants and consumer-directed agencies file as joint employers under the federal Fair Labor Standards Act. Under joint-employment, participants are responsible for supervising and training their attendants while the consumer-directed agencies are responsible for billing Medicaid and providing other fiscal intermediary services. The agencies pay attendants' wages, payroll taxes, and unemployment and workers' compensation insurance. Some consumer-directed agencies also provide medical benefits. Agencies must use at least half of their revenue to compensate direct support workers. Wages range from $10 to $13 per hour out of the $21 per hour reimbursement.

Consumer-directed agencies market personal assistance services through several means, including phone book advertisements and making information available at senior meal sites. Some consumer-directed agencies provide services across the state and some serve local areas, so participants have choice among consumer-directed agencies.

Consumer-directed agencies provide fiscal intermediary services and training to participants.

Agencies also provide assessments to determine people's eligibility for services. When a participant first requests CDPCP, consumer-directed agency staff assess the participant's strengths and needs. In more remote settings, agency staff may not be able to assess the individual promptly due to travel conditions. For example, staff may need to board a ferry for several hours to meet a participant who lives on an island. If assistance is urgent, a local health service agency (e.g., home health agency) can provide the assessment. After eligibility is determined, the participant directs the service planning process, which is reviewed annually by the consumer-directed agency and the participant.

Supervision of tasks by Registered Nurses is not required in the CDPCP. Alaska's Nurse Practice Act does not apply to attendants who provide supports that are incidental to the person's health care needs. Participants can supervise their services in place of a registered nurse.

Implementation

Alaska developed CDPCP after state staff held a Personal Care Summit to discuss the future direction of Alaska's personal assistance services in November 1998. Summit participants were recruited using the Division's mailing list. Seventy-five providers, service participants, and state agency staff attended the summit. Summit participants selected a Personal Care Attendant (PCA) Design Team to facilitate the design process for changing Medicaid personal care. This team consisted of service participants, advocates, providers, and staff from five state agencies involved in home and community-based services.

The PCA Design Team summarized the summit's results into two documents. A one-page "Guiding Principles for Personal Care Attendant Services," emphasized the need for participant controlled, community-based services available to all eligible Alaskans 24 hours a day as needed, and allowing communities to develop services meeting the communities' unique needs. The second document, a two-page "Recommended Ideas for Improvement," supported equal Medicaid reimbursement for agency-based and consumer-directed services, expanding Medicaid-reimbursable services, allowing participants to choose not to have

supervision by registered nurses, and other changes to support the "Guiding Principles".

The PCA Design Team sent the documents to state department commissioners, division directors, and other Summit participants. After reviewing the documents, the commissioners gave the PCA Design Team permission to move forward. The team created draft regulations using the two documents and feedback from September 2000 surveys of participants and providers. The surveys evaluated satisfaction with PCA services and training, the assessment process, nurse supervision, criminal background checks, and back-up services. The survey also asked people to identify general strengths and weaknesses of the agency-based and independent provider programs. The regulations became effective in October 2001. The state allocated one .33 FTE for the two year planning of the CDPCP and two employees totaling .60 FTE for the implementation of the CDPCP.

Impact

The CDPCP significantly increased the number of people directing their personal care. Only 187 of 1,925[1] personal care participants (10 percent) hired independent providers during state fiscal year 2001, the year preceding CDPCP. Two years later, 75 percent of 2,700 personal care participants hired attendants through CDPCP agencies.

Personal care expenditures also rose since CDPCP began. Between 2001 and 2003, expenditures increased 420 percent from $8.5 million to $44.2 million[2] while the number of participants increased by 40 percent. One factor was the conflict of interest in personal care agencies' roles. For both consumer-directed and agency-based care, agencies assess participant eligibility, work with participants to develop the service plan, and receive payment for services.

The Department of Health and Senior Services changed the program in 2004 to increase oversight of personal care agencies. The department increased audits of personal care assessments and service plans. Also, new regulations require state approval for participants receiving more than 35 hours of personal care in a week (state approval was previously necessary for more than 56 hours). These regulations also allow the department, at its discretion, to conduct a person's assessment and to assist in service planning instead of allowing the personal care agency to perform these duties.

Contact Information

For more information about Alaska's Consumer-Directed Personal Care Program (CDPCP), please contact Diane Dishman at 907-269-3652 or diane_dishman@health.state.ak.us. More information about CDPCP is available at http://health.hss.state.ak.us/dsds/pca/home.htm.

Discussion Questions:

What process changes would be necessary to establish principles and develop program changes in more populated states?

What are the advantages and disadvantages of using consumer-directed agencies to support participants who hire their own providers, rather than allowing participants to hire independent providers?

This report was written by Erin Barrett, M.S.W. and updated by Medstat. It is one of a series of reports by Medstat for the U.S. Centers for Medicare & Medicaid Services (CMS) highlighting promising practices in home and community-based services. The entire series is available online at CMS' Web site, http://www.cms.hhs.gov/promisingpractices/. This report is intended to share information about different approaches to offering home and community-based services. This report is not an endorsement of any practice.

[1] Most participant data is from the State of Alaska. 2001 total personal care participant data is from Center for Personal Assistance Services. "State by State Medicaid Home and Community Based Services for 2001".

[2] Expenditure data from Brian Burwell, Kate Sredl, and Steve Eiken. "Medicaid Long Term Care Expenditures in FY 2003" May 25, 2004.